CHANGES TO THE IFSP

State Form 51841 (R3 / 1-07) / BCD 0113

First Steps

		County
Name of child	Date of birth (*month, day, year*)	Date of IFSP (*month, day, year*)

JUSTIFICATION

Decrease in services due to:
- ☐ Outcome achieved
- ☐ Progress being made toward outcome
- ☐ Cost participation
- ☐ Other parent reason / preference: _____

Increase in services:
Please attach the Documentation of Team Discussion form. For new services, please attach a new Outcome page. For all increases, include a narrative explanation from the team describing the intent and rationale for the service increase.

MODIFICATIONS: ***The Team is recommending the following modifications, as listed below.***

Use (+) to add (-) to terminate	Modification in service(s)	Related to outcome number	Frequency / Intensity (*times per week or month / minutes per time*)	Anticipated Start Date (*month, day, year*)	End Date (*month, day, year*)	✓ if on-site	Location Code	Provider Information (*include name of provider and payee*)

I/We participated in the IFSP review process and agree with the revisions reflected in this section. I/We understand that changes in service that results in an addition or increase of a service requires the consent of my child's physician. Once signed by my child's physician, I/We give informed, written consent to implement the services described in this document. A copy of this completed modification page will be distributed to members of our IFSP team once all signatures have been obtained. I/We have received a copy of parent's rights for the First Steps Intervention System and had these rights explained verbally by our Service Coordinator.

Signature of parent / guardian / foster parent / surrogate parent (*required*)	Date (*month, day, year*)	
Signature of parent (*other*)	Date (*month, day, year*)	
Signature of service coordinator (*required*)	Date (*month, day, year*)	
Address of service coordinator (*number and street, city, state, ZIP code*)	Telephone number	Fax number
Printed or typed name of physician	Telephone number	Fax number

Listed below are the services that the child is expected to receive once the modifications are approved:

Related outcome	Service	Intensity / frequency	Anticipated Start Date (*month, day, year*)	End Date (*month, day, year*)	On-site (✓)	Provider Name and Agency

Once you have reviewed the above modifications to the IFSP, please indicate your agreement with the services planned for this child and family in the space provided. Please return this signed form to the Service Coordinator listed above and retain a copy with the IFSP document in your patient records. If for any reason you do not agree with the services set forth in the IFSP, please contact the Service Coordinator immediately to discuss your concerns. You may also attach comments to this form.

Signature of physician	Date (*month, day, year*)